Interpreting in mental health, roles and dynamics in practice

Elena Resara[a,b], Rachel Tribe[a,b]* and Pauline Lane[c]
[a]School of Psychology, University of East London, London, UK; [b]Berlin, Germany; [c]School of
Health Studies, Anglia Ruskin University, Cambridge, UK

Abstract

In mental health, communication is the *sine qua non*, not only for considering a

diagnosis, but also for developing a treatment plan. Provided that words, on the one

hand, and the relationship between the clinician and the service user, on the other, are

two of the main pillars of therapeutic treatment, the presence of an interpreter cannot

but exercise a major impact and may pose a series of challenges and opportunities for

all three members of the triad. This paper reports on a study conducted with

interpreters working with recent migrants, mainly refugees and asylum seekers at two

organisations based in the South of England. Two focus-groups with interpreters were

conducted. Several differences between interpreting in mental health and interpreting

in other settings were noted by the interpreters. Five over arching themes were

identified in this study.   These were the role of the interpreter in the mental health

encounter, the dynamics within the therapeutic triad, the interpreter : counsellor

relationship, power and alliances within the room and the personhood of the

interpreter. The first three themes are presented within this paper.

Key words: Interpreter, mental health, challenges and opportunities , roles, dynamics,

Most frequent reactions and mental health disorders

Recent migrants including refugees and asylum seekers can suffer from a range of psychological difficulties, similar to those experienced by any member of the population (Moussaaoui & Agoub, 2011). How ever any psychological difficulties experienced prior to migration may be exacerbated by the need to adapt to the wide range of changes associated with migration (Ruiz et al 2011). In addition refugees and asylum seekers are likely to have faced a range of difficult and potentially traumatic events prior to fleeing from their country of birth to seek asylum in another country, these experiences are often detrimental to good mental well being (Somasundaram, 2011). Asylum seekers will face a further period of uncertainty pending a decision on their asylum application, which is likely to be very stressful as they wait to hear if their application for asylum has been successful (Tribe, 2005). Some migrants may suffer from a range of difficulties which can range from florid psychotic illness to issues of adaptation and a poor sense of well being. Although some migrants including refugees and asylum seekers will require access to services, some will not. It is important to note that some studies have noted that some migrant groups may experience better mental health than that of the local population (Levecque et al al 2009; Tkeuchi et al 2007). Increasing numbers of people migrate across national borders with a current estimated number of two hundred million (200,000) international migrants (United Nations Development Programme, 2012). Many of these people may need to access services in a country in which they are not fluent in the host language and will require the professional assistance of an interpreter, this is an issue which requires attention. The World Psychiatric Association has identified mental health and subsequent care as a priority (Maj, 2011; Bhugra et al, 2011). The presence of an interpreter brings additional opportunities and challenges into the clinical encounter (Tribe and Thompson, 2009). A review of the literature on migration and mental health can be located in Bhugra & Gupta, 2011.

Methodology

The research will analyze the dynamics of interpreter-mediated psychotherapeutic encounters with migrants from the point of view of interpreters, "whose voices have been noticeably absent from the literature……" (Miller et al. 2005: 28). Given the paucity of specific studies on interpreting in mental health settings in general and with migrants in particular, an exploratory approach has been adopted, together with a qualitative, inductive research method, namely focus groups.

Sampling and informed consent: A convenience sample of 12 interpreters working for two charities working with migrants in therapeutic settings in the South East of England, were interviewed. Ethical approval was given by the charities and the interpreters all gave individual informed consent prior to meeting in the focus groups. It was made clear to the interpreters that they were free to choose to take part in the focus groups, or leave at any point, if they wanted to. They were also made aware that

participation in the focus groups did not, in any way, impact on their employment within the charities. The interpreters were also informed that the data from the focus groups would be recorded and that their comments would be anonymised and used for the analysis and that quotes would be used in the final paper.

THE FOCUS GROUP RESEARCH METHOD[1]

Kitzinger (1995: 311) defines focus groups as "a form of group interview that capitalizes on communication between research participants in order to generate data". A moderator guides the discussion by introducing a particular set of topics, which mirror the research questions which are developed from the existing literature and other relevant sources of information. The group discussion is recorded and the resulting transcriptions constitute the data for analysis.

BUILDING FOCUS GROUP QUESTIONS

Focus group questions were constructed by following a "funnel design", as suggested by Morgan (2000), from broader to narrower topics:

1. The top of the funnel: a few open-ended questions, aimed at discovering new insight or unveiling unanticipated issues. Here, participants can explore the topic from their own perspective. This section has been dedicated to the role of the interpreter in mental health.
2. The middle of the funnel: a set of predetermined but broadly defined central topics are proposed at this level, these are developed from reading the published research.
3. The bottom of the funnel: a number of narrowly defined issues are addressed at this point, through specific questions requiring specific answers. This last phase was meant to explore the potential duty-related effects of the work on the interpreters' sense of well-being.

Table 1 Interpreters' focus topic group questions
TOP - The role of the interpreter in mental health

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1. In your opinion, what are the most important characteristics of a good interpreter in mental health with migrants?
2. According to published guidelines the personal qualities that a clinician should aspire to include the following: empathy, sincerity, integrity, resilience, respect, humility, competence, fairness, wisdom, courage. Which ones would you apply to the interpreter too and why? Any others?
3. What are the things that make the work in mental health with migrants different to any other interpreting work you did elsewhere?
4. In such a sensitive field as mental health, do you think you should aim at invisibility or involvement?

MIDDLE – The therapeutic triad

General:
1. Let's briefly talk about practical interpreting strategies. Do you tend to use the first or the third person? Do you tend to give a literal translation or to reformulate? What about non-verbal communication, how do you deal with it?
2. How do you think about or manage the triadic relationship?
3. Are issues of trust more apparent in this work or not?
4. Usually two types of alliances are created within the therapeutic triad: either between the patient and the interpreter or between the clinician and the interpreter; an alliance between the patient and the clinician is quite unusual. So basically in both cases you represent a point of reference. How do you feel about that?
5. Who would you say holds the power in the therapy room? How is it possible to empower the others?

Relationship with the patient/service user::
1. Tell us about your relationship with the patient/service user. How would you generally describe his/her attitude towards you?
2. How is your attitude towards him/her?
3. If the patient/service user does not belong to the same gender, do you think he/she avoids certain intimate topics? Have you yourself ever felt ashamed or disturbed because of the gender or other differences (origins, ethnicity, values, religion, age)?
4. Has it ever happened that you to have to interpret for a psychotic patient'? How did you cope with it, professionally and personally?
5. In psychotherapy, the clinician tends to respect some boundaries, for example to avoid any form of physical contact with the patient or not to share personal information. What are or should be the interpreter's boundaries, in your opinion?

Relationship with the clinician:
1. Now tell us about your relationship with the clinician. How important is the trust between the two of you in order to gain the trust of the service user ?
2. How do you organize your work together?

BOTTOM – The *self* of the interpreter
  1. Do you feel your work has any impact upon you, either positive or negative?
  2. Things you like about working as an interpreter in mental health with migrants? Things you dislike?
  3. How do you feel at the end of the session?
  4. Have you ever had strong emotional reactions during or after the session? How did you deal with it?
  5. What training/support do you get or would like to receive?
  6. Is there anything which would make your work easier?
  7. Is there anything else you would like to tell us which you think is important?

Anonymity of the participants was guaranteed by censoring names and other potentially identifying information (country of origin, spoken languages) from the final transcriptions.

Demographic data about interpreters

Table 2 **Demographic characteristics of participants**

Sex:
Female	83%
Male	17%

Age:
30-35	42%
35-50	25%
50-65	33%

Number of languages spoken:
2	33%
3	42%
4	17%
5+	8%

Interpreting training:
Formally trained	42%
Short course	42%
None	16%

Years worked as an interpreter:
0-5	22%
5-10	67%
10+	11%

Work settings:	
Legal services	50%
Social services	50%
Refugee services	75%
Medical services	50%
Mental health services	92%

PREPARING THE ANALYSIS

After the audio files were transcribed, they were coded by using the three coding procedures devised by Strauss and Corbin (1990). First of all, at the margin of each transcribed page, ideas and phenomena were labelled and categories of information were isolated (*open coding*). This information was then reassembled into thematic areas, which mirrored the initial research questions (*axial coding*). A descriptive, conceptual and comparative approach was then adopted in order to create a visual model that connected the various categories (*selective coding*). The final result was a set of theoretical propositions. Focus groups are not intended to generalize, but rather to gain a more complete and in-depth understanding of a particular topic. For use of terminology see footnote [2]

Results

Participants' answers are grouped into thematic areas, which mirror the original research questions. Results are organized around key themes, mirroring the structure of the initial questions. Quotes have been selected which illustrate a wider theme.

DIFFERENCES BETWEEN INTERPRETING IN MENTAL HEALTH AND OTHER SETTINGS:

Interpreting in mental health with migrants has previously been described as an atypical form of community interpreting, with unique traits. Working with migrants in mental health may require a certain amount of altruism and vocation:

- "Anyone can go and interpret, [anyone] who's done the interpreting training and got their language. But to work in mental health you have to have a certain amount of understanding of people who have mental health problems, how they view things and have a certain amount of empathy towards them and you're going to be working at a different level."

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[2] The general term clinician is used to include therapists, psychologists and counsellors. Research participants on occasions use the term advisor and counsellor and these have not been changed. The term service user is used rather than patient or client as this is viewed as more respectful and is in line with convention in the UK.

However, the other side of the coin is a higher level of involvement of the interpreter or at least the perception by interpreters that working in the mental health services requires more involvement than other fields.

* "I was trained for legal interpreting. And if you think that the lawyer is not good, you are not there to say to that client: you should change the lawyer. You just cannot do that. There is also the question of liability, there is also the question of if you say the wrong thing you can be liable for that. And I noticed with mental health interpreting the first thing that was like "wow", was when they say that sometimes the clinician or the practitioner would say to you: what do you think about that client?"

Especially when the interpreter and the patient have common origins, involvement can become overwhelming, something which does not frequently occur in medical or legal settings. The impact of duty-related stressors on the interpreter's mental well-being can be an issue of concern.

- "It's not easy [to be emotionally detached], because it is in your mind. They're people, they're human beings like you. That person is suffering and you're listening to whatever she's suffering from and it's not easy to forget or to cancel it from your mind. It's natural because you know how they're coming and how they're suffering, so for me it is hard."

This poses a significant dilemma to interpreters. On the one hand, they struggle to stick to their prescribed 'invisible' role. On the other, as they build a relationship with the service user, they gradually develop a growing feeling of empathy and a true desire to directly help them. They recognize that this does not happen in other community interpreting settings:

- "We often end up being piggy in the middle. On one hand, we want to be the professionals who can help the client and get them to access the service better, so they go away feeling much better and the clinician feels better that they've been able to provide that service. And if that happens, great! You feel like I've done my job. But if you end up being torn, you know, pulled. That's your conscience he was pulling out... It happens to us all the time and it's very difficult to stop yourself from becoming emotionally involved.."

Another aspect which casts mental health interpreting as different, is the total unpredictability of each session, not only in terms of content, but also in relation to the patient's behaviour and reactions.

- "You don't know especially with mental health people how they're going to be when you're interpreting."

As a consequence, interpreters must be prepared to adapt their modes of interpreting to every case they deal with. In the instance below, the interpreter recounts how she acts when the patient keeps on repeating 'nonsensical' things over and over again.

- "Having that extra bit of appreciation of the fact that when we are sitting and talking we will talk in a different way at a different speed perhaps. [...] People in mental health, often you find they may keep repeating things and a normal person would get annoyed with that because,

Gosh, they keep saying the same thing over and over again. So you have to be mindful of those things and also of the fact that whatever they're saying you have to interpret for the clinician to make their own judgement even if you think it's quite silly."

For all these reasons, interpreters recommend avoiding the use of sessional ad hoc interpreters. To begin with, they are not sufficiently experienced in mental health to be able to work efficiently. Moreover, the patient gets confused by a continuously changing therapeutic triad, and building the necessary trust relationship becomes unattainable.

- "For mental problems I advise they have interpreters always fixed for that job, because if the interpreter comes from an agency, he doesn't even know how to interpret and maybe he doesn't know how to deal with the client or with the advisor."

THE ROLE OF THE INTERPRETER IN MENTAL HEALTH ENCOUNTERS

Interpreters were asked what was the most important requirements an interpreter should have when working in mental health with recent migrants..

1. THE ROLE OF THE INTERPRETER WITHIN THE CLINICAL ENCOUNTER

1.1. DEFINING PROFESSIONALISM

The majority of interpreters cited similar factors, namely confidentiality, excellent knowledge of the patient's language and culture, good communication skills and positive interpersonal attitude. Typical answers include:

- "Good listener. [...] Understanding properly what they are saying."
- "It's good to know the culture, religion and customs of every client."
- "And also to be […] confidential, you have to keep the confidentiality."
- "…We need to be patient."

However, when specifically referring to the meaning of professionalism, interpreters' views seem to mirror the merely prescriptive approaches of guidelines and codes of conduct. The importance of "being professional" was reiterated many times, with a range of nuances. Yet, emphasis was predominantly placed on what *should* be done, rather than on how things are actually done:

1. Being precise:
   - "You have to translate everything in words from both sides."

2. Being emotionally detached:
   - "You do have to have empathy but you also have to know yourself where to kind of draw the line and be a professional."

3.   Being firm:
   - "It's all about how to be an interpreter actually because you have to be in both sides at the same time and you have to be very firm with your skill."

4.   Knowing how to behave in relation to a specific culture:
   - "Each person can have all sorts of experiences so all are included in it, like body language, eye contact, sitting arrangements everything is in here, so when I say professional it means that you have everything all together."

5.   Being neutral and impartial:
   - "When you go to train to become an interpreter the first thing they say to you is confidentiality and also you have to be impartial."

Professionalism appears to be an all encompassing formula embracing a number of behaviours which, again, *have to* be adopted. So much so, that one interpreter says:

   - "You know, you are working for this organization and you have to do everything in the way it is said or it is in your policy."

In reality, actions may belie words as interpreters' subsequent recounting of personal experiences and practical cases contradict the "rules" mentioned above.

1.2 THE PARADOX OF INVISIBILITY

The paradox of invisibility appears emblematic, as the following will highlight. The interpreter's invisibility was conceptualized through various metaphors, mirroring the notions of *animator* and *reporter*, as postulated by Goffman (1981) and Wadensjö (1998). Examples of the metaphors used by interpreters are given below:

   - "You are just an interpreter there and you are [...] we say "<u>tongue</u>" of that person because you're going to speak on behalf of that person, cause you're going to translate everything from that language to the counsellor's language. [...] In a way, you're just a <u>language</u> between two people, because you are the <u>communicator</u>, you are the one who passes one information from one to another."
   - "We are <u>messengers</u>.."

In fact, the multifaceted active roles played by interpreters emerge from their narratives. For the sake of clarity, these roles will be partially illustrated by adopting the classification system proposed by Leanza (2005) and partially by listing other roles tailored to mental health interpreting.

1.2.1. Interpreters as active translators

Interpreters working in mental health with recent migrants confront a series of specific difficulties at the linguistic level, which require a number of strategies. In fact, literal translation is often unviable in mental health encounters as in many others settings (as highlighted by Wadensjo: 1998; Berk-Seligson: 1990). For this reason, interpreters facilitate communication by actively intervening at a linguistic level. In

psychotherapeutic encounters, challenges may arise due to the patient's use of language or social and ethnic origins as one interpreter clearly said:

- "Sometimes they speak like slang language (in mental health)."

Other linguistic dilemmas are related to the patient's specific mental health condition. For instance, using the first person to minimize the interpreter's presence can be tricky, as the service user might confuse roles within the therapeutic triad:

- "If I'm repeating in the same way what the clinician's saying, especially with mental health people, they may not understand, if I say: don't do that next time. Clinicians might be saying it directly and I cannot be that direct perhaps with them."

It seems, from what respondents said, that a verbatim, totally neutral translation might make communication more difficult rather than facilitate it.

1.2.2 Interpreters as cultural informants/brokers

Invisibility wavers when the interpreter is asked to inform the clinician about the patient's cultural norms and to negotiate between two diverse cultural systems. Participants highly valued this role, as shown by the following statement

- "I.'s from [African country] she knows the culture of that country. She can tell the advisor: no need to shake her hands or you should not look into that client's eyes because it's not nice."

Likewise, the interpreter clarifies Western mental health constructs to the patient, with special attention to how his or her culture perceives psychological distress:

- "And also asking them those kind of questions [about their mental health] is something that is really hard for some cultures because it's like you're telling them you're mad and not everyone is going to be able to say: well I have some mental problems. Because for some cultures it is an insult. You can't just tell someone that you're mental, so you have to explain to them."

1.2.3 Interpreters as co-constructionist/therapist

If there is one aspect, which refutes the notion of interpreter invisibility mentioned earlier, it is perhaps the interpreter's role of co-constructionist/therapist. The interpreter is actively involved in the therapeutic process and is requested to express their opinions about the patient. Interpreters are more cautious in revealing this facet. Yet, as the example below indicates, when directly asked, they admit playing a part in exploring the mental well-being of service users.

* "We need to understand [...] why they are angry or why they are frustrated or they're acting like this because they have a lot of problems. Some clients feel like this, they don't have money, they don't have accommodation and they don't have where to go, so if they are acting or they are raising their voice

loud, you need to understand them because it causes them pain."

1.2.4 Interpreters as (almost) therapists

Sometimes, the interpreter's role appears to go even beyond that of co-constructionist/therapist. It occurs rarely, but cases were reported in which the interpreter personally appears to give psychological support and reassures patients in crisis, through understanding their cultural norms and those surrounding mental health in the UK, for example:

- "One of the clients [...] had made a [...] mental health appointment, in Sri Lanka actually mental means you are really mad. So when her brother saw that appointment obviously he thought she's mental. [And] she was just scared about the appointment, she started to cry, she asked us: am I mental? You know seeing me, and I said like: no, mental health [...] covers many different meanings so I had to explain like it doesn't mean like you're mental actually, don't worry."

As seen here, the myths of the interpreter's neutrality, impartiality and invisibility are frequently challenged in clinical practice. A number of roles emerged during the focus groups. The interpreter acts as an active translator, who is expected to detect hidden meanings and facilitate conversation, as a cultural informant/ broker, who mediates between two different cultural systems, as a co-therapist, who expresses his or her opinions about the service user or about the assessment, and occasionally even as an (almost) therapist, who personally and directly deals with patients in crisis.

2. THE DYNAMICS WITHIN THE THERAPEUTIC TRIAD

Before examining the alliances and power dynamics within the therapeutic triad, the dyad of interpreter-patient will be explored, with special attention to the foundations upon which a positive relationship can be built as well as the challenges that can potentially undermine it.

2.1. INTERPRETER-PATIENT DYAD

Some crucial variables characterize the relationship between the interpreter and the patient, namely trust, issues connected to the patient's mental condition, mechanisms of transference and counter-transference, boundaries and different gender, religion, political views and cultural background.

2.1.1.Trust

All the interpreters both agreed on the crucial importance of building a trusting relationship with the patient for the clinical work to be fruitful. Trust is considered as the foundation without which therapy is not only difficult but even unfeasible. As the

following quotation proves, much depends on the interpreter's ability to reassure the patient about the accuracy of the conveyed message, without showing any strong emotional reaction:

- "Without the trust they're not going to pour out. And if they're not going to pour out, they can't, the clinicians can't help them. So that trust is extremely, is probably crucial in the situation. The client needs to know that everything they're saying, you're passing on and they can say anything and that's why you can't show either shock, or disgust or any of your own emotions about what they're saying to you, because instantly they would stop being open."

Interpreters listed a number of strategies to gain the patient's trust through their body language and general attitude. Among the most significant examples:

- "Sitting position, eye contact with client, body language. Everything is so important because you cannot just look at the wall and interpret for client and advisor... Manner, you know, you have to show that you *are* with that person. [...] Eye contact is very important for both sides [...], especially in mental health, in those sessions it is very important, because [...] when you have eye contact with the client, it shows that you're trying to help and understand, cause eye contact mean a lot to a person."

Finally, one of the interpreters placed special emphasis on the importance of the first meeting for trust to be established. At the same time, the very fine line that interpreters should not cross in their interpersonal relationship with the patient is openly acknowledged:

- "They have to trust you, you have to gain that. So in the first meeting you have to make sure it goes well, in order to gain their trust. But you have to stop them from becoming too emotionally attached to you, so that's, as a professional, that's the one thing you aim for. And they do trust you but they don't think you're their friend. So, you're befriending them in a way, but not becoming their friend."

2.2 Issues connected to the patient's mental condition

One of the key destabilizing factors of a positive relationship between the interpreter and the patient was thought to be connected to the patient's mental condition. The interpreters had all experienced patients' angry, sad or 'raving'
 reactions, but they responded with calmness and patience and the relationship appeared to be left unscathed:

- "Sometimes [patients] are pressing and violent and we need to be patient. We need to understand what is the cause of this anger or why they are angry or why they are frustrated or they're acting like this because they have a lot of problems. Some clients feel like this, they don't have money, they don't have accommodation and they don't have anywhere to go so if they are acting or they are raising their voice loud you need to understand them because it causes them pain."

2.3. Boundaries

Service users often place unrealistic expectations upon interpreters because of their linguistic and cultural ties to the interpreter. However, this can result in boundaries being crossed and even broken as interpreters stated during our focus groups:

- "Sometimes you're stuck because that client expects lots from you because he says: oh this is someone from my country, he can help me more."

Our focus groups analysis highlights that boundaries and boundary crossing are defined and understood from several angles by respondents:

2.3.1. From the interpreter to the patient.

Interpreters should not physically touch service users to give them support in moments of crisis:

- "Some of them do cry because everybody have a different way of expressing their feelings. As an interpreter it's hard because you can't really touch them to say: it's alright, so you just have to kind of stay there and see. [...] But sometimes I do ask if they can give them a tissue [...] or water or something like that. Because when they cry you just have to look at them and you can't really support much."

Service users and interpreters should minimize the possibility of interaction outside the therapy room:

- "And the other thing we like to do is you only meet the client in the session, not outside and you don't leave with him either, so that is left to the clinician. …So you don't walk out and the client's still befriending you and we're told not to do that."

2.3.2 From the patient to the interpreter.

Patients should not ask for something to be hidden from the clinician or for personal favours:

- "You have to tell the clients that whatever it comes out from their mouths it has to be translated and they have to watch themselves, they should not ask you for any favour or something that the advisor doesn't want to hear. Just like, if you want to harm yourself I have to tell that, because that's what happens sometimes they say: well I am going to kill myself but don't tell the advisor."

2.4. Issues of gender, religion, political views, cultural background

Different cultural backgrounds and religious or political ideologies may be influential variables in establishing a good relationship between the interpreter and the patient, similarly to gender. Unquestionably, the latter poses a series of relevant clinical questions. Indeed, a man may not be at ease if interpreted by a woman, and vice versa.

- "I remember in training with an Iranian woman, she was saying she had a male client in counselling sessions and she sensed that, as an Iranian man, he wasn't that comfortable with her. And she said that at the end they were doing relaxation exercises and she sensed that he was not comfortable, so she said: ok, his language was ok to understand, so she left the room at that point. [...] So that can be an issue sometimes."

In summary, the role of the interpreter in mental health encounters has been explored, revealing some differences between prescriptive norms and actual behaviours of interpreters. Special emphasis was placed on the thorny question of interpreters' invisibility versus their active participation and multifaceted roles. Several differences between interpreting in mental health and interpreting in other settings were also discussed.

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